The patient nobody liked

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Mr. L's recurrent suicidality and aggressive, disruptive behaviors anger patients and hospital staff. What is his diagnosis? How would you get him to stop 'acting out'?

CASE He bares it all

Police have arrested Mr. L, age 62, 3 times in 36 hours after spotting him walking naked in public. With the county jail jammed to capacity, police bring him each time to our hospital's emergency room.

After his first arrest, Mr. L matter-of-factly tells us, "I want to walk naked and starve myself to death." His self-harm exhortations amplify with each visit until—at the third presentation—he reports that he has not eaten for at least 2 days.

Mr. L had been living on the streets for nearly 1 month. Before that, he had been in jail for approximately 1 month after attacking a nursing home patient. He has been hospitalized twice in 5 months for severe depression and personality disorder and has engaged in numerous disruptive behavioral episodes and feeble suicide attempts. At this latest presentation, he appears disheveled and lacks judgment and insight into his condition.

We readmit Mr. L to the psychiatric unit to re-evaluate his treatment. He had been on citalopram, 60 mg/d, and aripiprazole, 10 mg/d, but he says he stopped taking the medications because they were not improving his mood.

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What diagnosis do you suspect?

a) a psychotic disorder
b) depression with psychotic features
c) depression without psychotic features
d) a personality disorder

The authors' observations

We readmitted Mr. L with working diagnoses of:

- major depressive disorder with psychotic features, based on his suicide threats and complaints of depression
- personality disorder not otherwise specified, based on his behavioral episodes, apparent desire to be cared for (***Table 1***), and refusal to "get better" during 2 recent hospitalizations.

HISTORY His best friends

As a child, Mr. L had no friends. His father was physically present but emotionally distant, so he relied on his mother for emotional support. Throughout his teens and early adulthood, his mother continued to do his laundry, buy his food and clothes, and run his life. When he married in his early 20s, his wife assumed this role.

Mr. L avoided psychiatric care for most of his life but did not socialize outside the house, lacked ambition, and seemed content to depend on his wife. He worked primarily

Table 1

A troubled life: Mr. L's history

Period	Mr. L's difficulties
Childhood	Has no friends in school; his mother—Mr. L's sole source of emotional support—continues to wash his laundry, buy his food and clothes into his 20s
Adult life	Keeps 'goofing off' at work and has trouble staying employed; depends on wife to manage his life
2 years ago	Shows depressive symptoms (amotivation, lack of concentration, increased fatigue, decreased appetite) after shoulder injury Develops irrational fear that household appliances will malfunction Becomes hostile toward his wife of 34 years
5 months ago	Hospitalized after threatening to kill wife; has depressive symptoms and is disruptive during month-long hospitalization
4 months ago	Discharged from hospital to homeless shelter because estranged wife won't allow him back home; is readmitted after shelter staff find him banging his head on an iron gate; again behaves disruptively
3 months ago	Discharged from second month-long hospitalization to nursing home
2 months ago	Attacks patient at nursing home; police arrest and incarcerate him on disorderly conduct charge
Past month	Released from jail after 1 month and spends weeks on the streets; lands in ER after police repeatedly catch him walking naked in public

Clinical Point

Mr. L showed average global intelligence and delays in visual-motor speed, visual working memory, and alertness to environment

as a janitor or housekeeper but was constantly getting fired and drifted from job to job. His wife told us that when he was supposed to be working, he spent hours staring at the walls and watching TV.

Mr. L's recent troubles began approximately 2 years ago, when he suffered a shoulder injury. He underwent physical therapy but refused needed surgery because he lacked money and health insurance.

As the shoulder pain intensified, Mr. L quit his job. While out of work, he stopped attending physical therapy sessions when his depressive symptoms began to offset the shoulder pain. He suffered loss of concentration and motivation, increased fatigue with hypersomnia, and decreased appetite. He lost 10 to 12 lb in 1 year.

Mr. L also started having trouble "focusing on reality" and developed obsessive fears of malfunctions around the house, such as the furnace blowing up, the stove catching fire, or the toilet backing up. At one point, he began urinating and defecating in his pants to avoid using the toilet. He began to feel hopeless and several times tried to suffocate himself by placing a plastic bag over his head.

He also grew irritable, angry, and aggressive—mostly toward his wife, who increasingly feared him. He started blaming her for "everything wrong in my life" and began contemplating stabbing her to death or striking her head with a hammer.

Five months ago, Mr. L was involuntarily hospitalized for depressive symptoms, suicidality, and continued homicidal thoughts toward his wife. The attending psychiatrist started olanzapine, 5 mg nightly, for psychotic features, and citalopram, 10 mg/d, for depression and anxiety, and ordered one-on-one observation to prevent additional suicide attempts. Mr. L's shoulder pain had resolved by this time.

Three days later, Mr. L began refusing to eat. The psychiatrist then increased citalopram to 20 mg/d and olanzapine to 5 mg

Clinical Point

The inpatient psychologist encouraged Mr. L to express his anger verbally instead of through offensive behavior

bid and asked a hospital internist to evaluate for malnutrition and a psychologist to gauge cognitive and intellectual function.

During the psychologist's evaluation, Mr. L showed average global intellectual functioning but delays in visual-motor speed, visual working memory, and alertness to his environment. These findings, however, did not explain the patient's lower functioning at home or in the hospital.

We ruled out organic causes for Mr. L's cognitive deficits after receiving normal brain MRI, urinalysis, rapid plasma reagin titer, and thyroid-stimulating hormone test results. We also ruled out malnutrition because vitamin B12 and folate levels were normal but ordered a dietary consult to help Mr. L regain weight.

Staff and family registered Mr. L for Medicare and Medicaid benefits so that he could become more independent, but his behavior soon regressed. He complained that staff and family were ignoring him and started urinating outside the bathroom, eating and smearing his feces, and bothering other patients. Staff directed Mr. L's wife to ignore his verbal abuse over the phone and encourage him to stay motivated for treatment.

Mr. L's disruptive behavior stopped after the psychologist tried individual therapy with behavior modification. The psychologist helped him devise a cleanliness plan and encouraged him to express his anger verbally rather than acting out. When Mr. L smeared his feces, he was to scrub the area with soap and water, take a 5-minute cold shower, put on clean clothes, and write and read an apology to hospital staff.

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DISCHARGE Nowhere to go

One month after admission, Mr. L was free of suicidal and homicidal thoughts and other symptoms. Staff prepared him for discharge, but his wife was contemplating divorce and refused to allow him back home. He also declined community outpatient treatment because he wanted his life to return to "normal" and was unaware that he was harming himself and others.

With no other disposition options, we discharged Mr. L to a homeless shelter. Later that day, shelter staff brought him back to the ER after they found him banging his head against an iron gate. We readmitted him to the psychiatric unit, at which point he endorsed suicidal thinking.

READMISSION 'Cold' case

During this second hospitalization, Mr. L was again eating his feces as well as coloring himself with green markers, writing obscenities on the wall, and tearing up other patients' papers. He repeatedly took 15-minute cold showers and told staff as they urged him out of the shower that he wanted to die by inducing hypothermia. During these episodes, he often called his estranged wife and told her what he was doing.

After the treatment team had Mr. L civilly committed, the attending psychiatrist titrated citalopram to 60 mg/d, discontinued olanzapine, and added aripiprazole to target the patient's underlying depressive symptoms. Aripiprazole was started at 5 mg nightly and eventually titrated to 10 mg nightly. On 3 occasions during the month-long hospitalization, Mr. L refused to take his medications because he felt he did not belong in the hospital.

The attending psychiatrist diagnosed "dependent, passive-aggressive behaviors" and noted that Mr. L was "not amenable" to psychiatric hospitalization. The treatment team and outpatient community mental health department decided the patient had a personality disorder and that continued hospitalization would prevent him from attaining autonomy.

We then discharged Mr. L to a nursing home. There, he demanded a transfer back to the hospital or to jail because he feared he could not afford nursing home care and believed he could receive more attention elsewhere. His request was rejected after our ER psychiatrist found him medically and mentally fit to stay at the nursing home.

About 1 month later, Mr. L tried to smother a female patient by holding a pillow over her face but stopped when she began to struggle. After he told the nurses what he had done, staff immediately called police, who arrested Mr. L and transferred him to the county jail.

Because police and nursing home staff viewed the incident as a cry for help rather than a cold-blooded attack, police charged Mr. L with disorderly conduct. One month later, police dropped the charge and released him to the streets.

As a clinician, how would you feel while treating Mr. L?

a) angry
b) sad/sympathetic
c) frustrated
d) disgusted
e) fearful

The authors' observations

Mr. L triggered hateful reactions among several treatment team members, many of whom felt vindicated by his arrest. Clinicians might react this way if they feel a patient is wasting their time, manipulating them, not recognizing their narcissistic need for the patient to change, or ignoring their treatment plans.[1]

Acknowledging the staff's—and your own—reaction to a difficult patient is critical. Not doing so can lead to treatment decisions based on emotions rather than evidence. In a busy clinical setting, it's easy to lose sight of this.

The following strategies can help you manage hateful countertransference, cope with a patient's offensive behaviors, and make appropriate decisions:

Related Resources

- Nagera H. Countertransference (PowerPoint presentation). Tampa, FL: The Carter Jenkins Center; 2003. www.thecjc.org/ppoint/ppoint/ct.ppt.
- MayoClinic.com video: Electroconvulsive therapy (ECT): One woman's journey. Click on "Video" at top, then scroll to title.

Drug Brand Names

Aripiprazole • Abilify
Citalopram • Celexa
Olanzapine • Zyprexa

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Clinical Point

Are your treatment decisions based on evidence or emotion? In a busy clinical setting, it's difficult to tell

- **Allow staff members to discuss their feelings.** Encourage them to acknowledge and discuss their feelings during team meetings or daily treatment discussions. This helped members of our team recognize that their identification with Mr. L's self-rejection fueled their desire to "reject" him by discharging him to police or the homeless shelter.
- **Joke about the patient's behavior when appropriate.** Humor is a mature and potentially healing defense mechanism. When not treating Mr. L, for example, we joked among ourselves about publishing a case report titled, "The case of the poop-eater." Never joke about the patient in the therapeutic milieu, where it can be disruptive.
- **See the behavior as a defense mechanism.** Viewing patients' reactions as defense mechanisms—rather than effects of a psychiatric disorder—can help you better understand the patient's underlying pathophysiology.

READMISSION More bad behavior

After his 3 arrests for public nudity, we readmit Mr. L, restart citalopram at 20 mg/d, and titrate it back to 60 mg/d to target his depression. We also switch back to olanzapine, 10 mg nightly, because the patient has seen little clinical benefit from aripiprazole and feels that olanzapine had improved his sleep.

In the psychiatric ward, Mr. L is once again disturbing patients, smearing and eating feces, and making half-hearted suicide attempts. Upset that staff is "ignoring" him, he enters other patients' rooms without invitation and urinates in places other than the bathroom.

Which diagnosis most closely fits Mr. L now?

a) major depressive disorder with or without psychosis
b) dependent personality disorder
c) dysthymia
d) antisocial personality disorder

The authors' observations

After 3 hospital admissions, Mr. L's diagnosis remained unclear (***Table 2***). At his first admission, his symptoms suggested major depression with psychotic features. With his subsequent behaviors in the inpatient psychiatric unit—including primitive suicide attempts and smearing and eating feces—Mr. L showed a strong desire to be cared for. This and his past dependence on his wife and mother suggested a severe dependent personality disorder.

At his first discharge, Mr. L was diagnosed with a personality disorder with significant passive-aggressive traits. His lifelong dysphoria and lack of ambition also suggested dysthymia.

With discharge from this latest hospitalization pending, we searched for options. We considered Mr. L's ongoing suicidality, persistent acting out, and aggression. Treatment team members discussed his use of "primitive defenses"[2] stemming from his limited coping skills in the face of severe depression.

TREATMENT A different course

One week after admission, Mr. L's inpatient psychiatrist recommends electroconvulsive therapy (ECT) to target the patient's presumed severe depressive episodes and disruptive behaviors. The psychiatrist is experienced in performing ECT, which in clinical trials[3] has shown efficacy in treatment-refractory major depression.

Table 2

Mr. L's differential diagnosis

Possible diagnosis	Mr. L's symptoms
Major depression	• Diminished motivation, concentration, and appetite • Increased fatigue, hypersomnia • Suicidal thinking
Personality disorder	• Primitive, dependent behaviors • Abnormal dependence on wife, mother
Depression with psychotic features	• Depressive symptoms with obsessive suicidal/homicidal thoughts, fears of household malfunctions

After giving informed consent, Mr. L receives 8 bilateral ECT treatments in 3 weeks. Also, the hospital psychologist performs behavioral modification similar to the previous cleanliness plan and again encourages Mr. L to express his anger and anxiety verbally.

By the second week of ECT, Mr. L's disruptive behaviors have ceased. By the end of week 3, his mood and motivation have improved to the point where he shows interest in becoming independent. He says he wants to show his estranged wife he can care for himself and eventually reunite with her.

As Mr. L continues to improve, we discharge him to outpatient community mental health services and continue citalopram, 60 mg/d, and olanzapine, 5 mg nightly.

Nearly 2 years later, Mr. L is living independently. He has been regularly seeing his psychiatrist at the community mental health center and is maintained on citalopram and olanzapine. He continues trying to make amends with his wife but is still out of work and receives Social Security disability benefits.

The authors' observations

Mr. L was fortunate that his inpatient psychiatrist could re-evaluate the diagnosis

after identifying the staff's significantly hateful countertransference. This allowed staff to offer ECT, which—despite its documented efficacy for major depression—is not widely available in the United States.

If no ECT providers were available, we would have considered medication change and long-term treatment in a state mental hospital until Mr. L showed he could care for himself.

References

1. Green LB. The value of hate in the countertransference. *Clin Soc Work J* 2006;34:188-99.
2. Vaillant GE. Ego mechanisms of defense and personality psychopathology. *J Abnorm Psychol* 1994;103:44-50.
3. Pagnin D, de Queiroz V, Pini S, Cassano GB. Efficacy of ECT in depression: a meta-analytic review. *J ECT* 2004;20:13-20.

Clinical Point

If the patient's depression is debilitating and ECT is not an option, consider medication change and long-term hospitalization

Bottom Line

Severe depression or disordered personality can lead to primitive behaviors. Combination antidepressants, antipsychotics, and behavior modification can reduce or stop the behaviors in most cases. Beware of hateful reactions to a patient's disruptiveness or nonadherence; encourage staff members to discuss these feelings among themselves outside the therapeutic milieu.